Department of Health
Child and Adolescent Mental Health Division

Performance Report

Performance Period July 2004-September 2004

Introduction

This report presents first quarter of fiscal year 2005 (July – September 2004) findings about the performance of operations and services of the Child and Adolescent Mental Health Division (CAMHD). The information is based on the most current data available, and where possible is aggregated at both statewide and district or complex levels.

CAMHD serves youth with intensive mental health issues, many of whom are experiencing complex life situations. Care coordination for these youth is provided statewide through eight Family Guidance Centers. Care coordination helps youth and families navigate the service system, and assures delivery of accessible and effective mental health services. Data tracking about the population and the provision of services is essential as it provides information about how well and how efficiently CAMHD is delivering care and impacting child outcomes.

CAMHD tracks data in four major areas: Population, Service, Cost, and Performance Measures. Population information describes the demographic characteristics of the children and youth served by CAMHD. Service information is compiled regarding the type and amount of direct care services provided. Cost information is gathered about the financial aspects of services. Performance Measures, including Outcome data, are tracked to understand and track the quality of services over time and the performance of operations of the statewide infrastructure designed to provide needed supports for children, youth, and families. Outcomes are further examined to determine the extents to which services that are provided lead to improvements in the functioning and satisfaction of children, youth and families.

How Measures Are Selected

CAMHD continues to report on measures of interest to the Federal Courts regarding the sustainability of improvements that have been made in the children's mental health service system in Hawaii. These measures are:

1) CAMHD outcome and results components will be implemented (Benchmark 22),
2) CAMHD will have developed appropriate CSPs for all children whose care is coordinated by CAMHD (Benchmark 26),
3) Service gap analysis (unserved youth report) will document that no child will wait longer than 30 days for a specified service or appropriate alternative…CAMHD will document in the quality improvement reviews that appropriate referrals are being made (Benchmarks 33 and 54-deemed completed),

4) Personnel and Vacancy Reporting,
5) Benchmarks that describe complex-based service testing, and
6) Complaints (no Benchmark attached, reporting requested by the Felix Monitoring Project).

Pursuant to the Stipulation for Step-down Plan and Termination of the Revised Consent Decree, this report also presents data by Family Guidance Center for numbers of children and youth served by CAMHD, percentage of care coordinator positions filled, and percentage of youth served who have a Coordinated Service Plan.

CAMHD Performance Management System

Use of data to improve services and service delivery

The CAMHD Performance Management system provides CAMHD with mechanisms to examine performance and use information to make decisions about needed adjustments to program implementation. Performance data in CAMHD are tracked across all aspects of service delivery and care. Data collection and analysis are conducted systematically and spans all areas of performance. This information is critical to determine how well the system is performing for youth, and how well youth are progressing. It is sensitive enough to determine if the system is performing better or worse for certain populations, and comprehensive enough to detect what aspects of care, and in what settings, problems may be occurring.

Services are monitored through tracking of trends and patterns found in utilization and satisfaction data, and examinations of practice and quality of services. For example, tracking of data from the point of registration to the initial receipt of service tells us how quickly youth are able to access care. The annual satisfaction survey tells us about consumer perceptions of services and service delivery, and what areas they think need enhancement. Tracking of data about critical incidents, such as elopements from residential programs, are sensitive indicators of how well programs are performing in providing safe and therapeutic environments. Case-based reviews of individual youth allow for focused looks at children's status, and how programs are impacting their progress.

As described in previous reports, the use of performance measures has proven to be a key tool in aligning the work of the organization to achieve results in core areas of service provision and supporting infrastructure. Because many measures have been tracked over the last three to five years (or more) the trending of performance over time has allowed for a unique perspective of the system transformation of mental health services for youth in Hawaii.

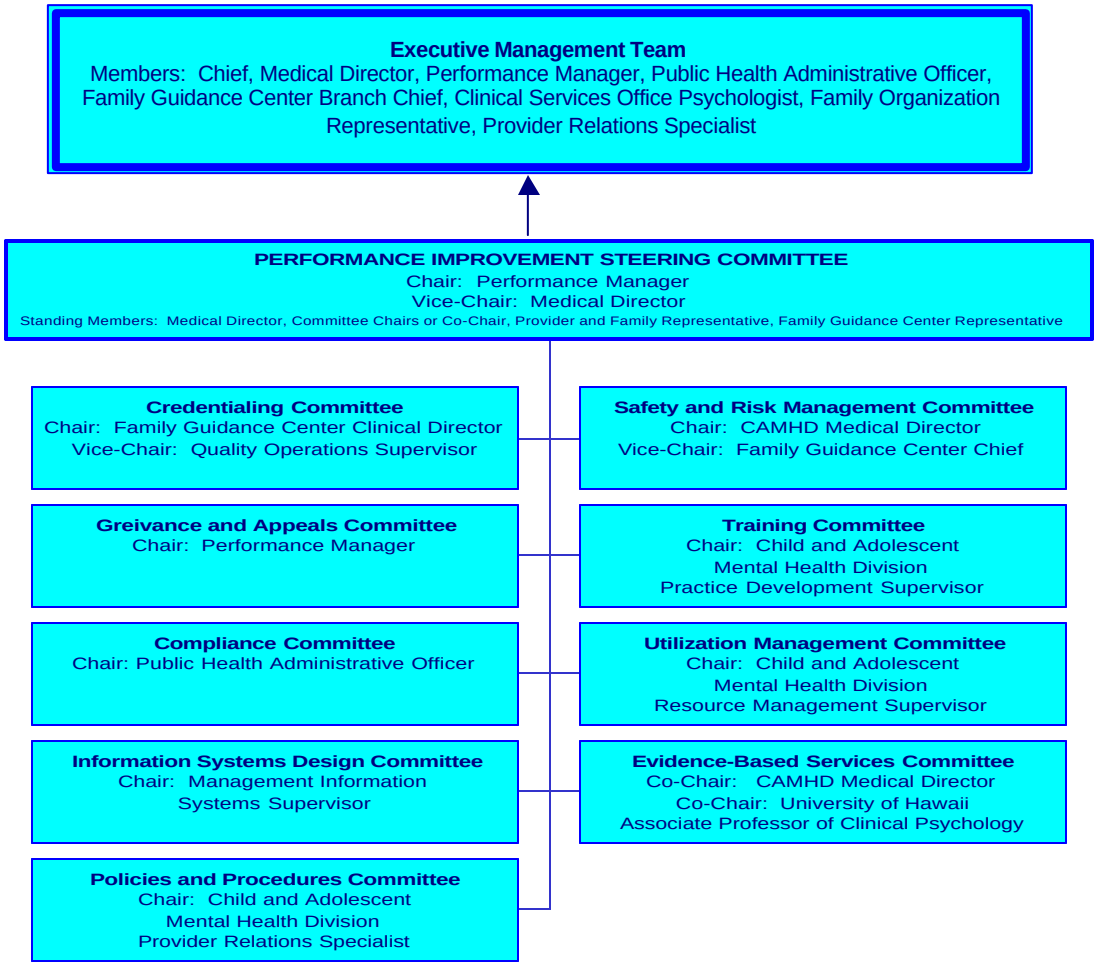
A key example of following change over time that paralleled the development of Hawaii's service system is found on pages 27 and 28 of this report. Rates of child improvement were examined to determine how quickly youth showed positive changes in their functioning during an episode of receiving services. The findings showed that by the end of the study (2004), youth were improving significantly more rapidly than at the beginning (2002). During the course of the study, CAMHD implemented numerous system improvements that coincided with significant improvements on the functional outcomes for youth served. This type of information affords important performance data regarding the impact of improvement initiatives.

Further studies and special reports on the CAMHD population and services, including past editions of this report can be accessed at the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/resources/index.html.

Quality management and accountability structures

The preponderance of performance measures in CAMHD are managed through two arenas that have distinct reporting structures. As the managed care organization providing intensive behavioral health services for Medicaid-eligible youth in Hawaii, CAMHD maintains an active quality assurance and improvement (QAI) program in alignment with national standards. Goals of the QAI program are achieved through an annual work plan that maintains improvement activities and measures for each objective. To assure accountability each measure has a designated monitor and timelines for data collection and reporting. CAMHD's nine quality management committees are involved in the selection of the measures. Accountability for reporting and implementing improvement activities are managed through the Performance Improvement Steering Committee, which meets monthly. Overall accountability and decision-making for improvement initiatives that impact the CAMHD program lies with the CAMHD Executive Management Team The CAMHD quality management committee structure serves as a core component of CAMHD's health plan operations.

The reporting structure for the QAI program is displayed below. The guiding documents for the QAI program can be found on the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/resources/library/pdf/qaip-2.pdf and http://www.hawaii.gov/health/mental-health/camhd/resources/library/pdf/qaip-3.pdf.



The CAMHD Central Office is the other primary arena that selects measures to guide operational quality and efficiency. The three major offices that make up the Central Office are Administrative Services, Performance Management and Clinical Services. Section managers from the offices are accountable for presenting their results to the Expanded Executive Management Team. The CAMHD Family Guidance Centers also maintain quality assurance committees and track measures relevant to improving services and operations for their local service areas.

Data Sources

Data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through CAMHMIS. CAMHMIS produces data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. CAMHMIS' multiple features include the ability to generate "live" client data, FGC-specific reports and other special reports that aid in performance analysis and decision-making. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level.

Population Characteristics

Population data presented here are for youth registered in the CAMHD Family Guidance Centers during the first quarter of fiscal year 2005 (July 2004-September 2004). In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,761 youth across the State, a decrease of 91 from the previous reporting quarter (April 2004-June 2004), or a 5% decrease in the total population. This is the first quarter, since the beginning of fiscal year 2004 that there has been a decrease in the population. Slight registered population decreases were experienced in all Family Guidance Centers with the exception of Central and Leeward FGCs. Since the same period last year (July 2003-September 2003), CAMHD has experienced a 6% overall increase in its registered population.

The numbers of youth registered at each of the Family Guidance Centers during the first quarter are displayed in Table 1. The numbers for Kauai (KFGC) are for the Mokihana Project in total, which serves youth with both low and high intensity mental health needs. The largest population continues to be served on the Big Island through the Hawaii Family Guidance Center (HFGC). HFGC served 24% of the total CAMHD population during the quarter. The Family Court Liaison Branch (FCLB), which provides services primarily for incarcerated and detained youth, had the smallest population and served 3.2% of the registered CAMHD population.

Table 1. Population of Youth Registered by Family Guidance Center, FY2005, Quarter 1 (July-September 2004)

COFGC	LOFGC	MFGC	WFGC	HOFGC	HFGC	KFGC	FCLB
144	206	163	143	149	424	475	57

The total number of registered youth are described by four subgroups: (*i*) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (*ii*) youth who were in the process of having services arranged (new admissions), (*iii*) youth who received less intensive services through Mokihana on Kauai, and (*iv*) youth who were discharged at some time during the quarter. There is also a percentage of youth who receive intensive case management services only. Of the total number of registered youth, 968 had services that were authorized within the quarter.

Of the registered population (1,761), 113 youth (6.4%) were newly registered (had not previously received services) in the first quarter of fiscal year 2005. This represents a decrease of 50 new admissions from the previous quarter (April-June 2004). One hundred twelve (112) youth (6.4%) were reregistered who had previously received services from CAMHD, a decrease from last quarter's readmissions of 147 youth. CAMHD discharged a total of 200 youth during the quarter, or 11.4% of the registered population. This is a decrease from last quarter's discharge of 259 youth (14.0% of the registered population).

Of the 968 youth who had services authorized in the quarter, 55 were new admissions (5.7%), 44 repeat admissions (4.5%) and 63 discharges (6.5%). Because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size.

The average age of youth, age range and percentage of males versus females continues to be stable among the CAMHD population. The average age of registered youth in the reporting quarter was 14.3 years with a range from 3 to 20 years. The majority of youth, as seen in Table 2 were male (67%). Based on clarifications from the Med-QUEST Division that the eligible population of QUEST enrolled youth extend through age 20, it is anticipated that CAMHD will begin to experience an increase in referrals for older youth, including those that may no longer be attending school. As this occurs, service utilization patterns for these youth will be tracked to determine if they have different types of service needs than the current population.

Table 2. Gender of CAMHD Youth

Gender	N	% of Available
Females	584	33%
Males	1,177	67%

The ethnicities of youth registered in the reporting quarter are displayed in Table 3. Those with Mixed ethnicities continued to represent the largest group (30.7%), followed by youth of Hawaiian ethnicity (23.2%). Non-Portuguese Caucasians made up the third largest ethnic group (21.2%), followed by Filipino (7.3%) and Japanese (3.7%). Ethnicity data was not available (no data entered) for 34.2% of youth registered.

Table 3. Ethnicity of Youth

Ethnicity	N	% of Available
African-American	28	2.4%
African, Other	0	0.0%
American Indian	1	0.1%
Asian, Other	8	0.7%
Caucasian, Other	246	21.2%
Chamorro	1	0.1%
Chinese	7	0.6%
Filipino	85	7.3%
Hawaiian	269	23.2%
Hispanic, Other	10	0.9%
Japanese	43	3.7%
Korean	3	0.3%
Micronesian	7	0.6%
Mixed	355	30.7%
Pacific Islander, Other	15	1.3%
Portuguese	34	2.9%
Puerto Rican	9	0.8%
Samoan	37	3.2%
Not Available	603	34.2%

There are subpopulations of youth who receive services through CAMHD that are also involved with other public child-serving agencies. These agencies include the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, and the Med-QUEST Division of DHS (see Table 4). In the quarter, 11.1% were involved with DHS, 27.4% had a Family Court hearing during the quarter, and 8.1% were incarcerated at HYCF or detained at the Detention Home. Youth who were eligible for services through the Serious Emotional and Behavioral Disturbance (SEBD) process numbered 458 and were 26% of the registered population. This was an increase of 75 youth in the SEBD category over the previous quarter (April-June 2004). In order to reduce stigma, and provide a family-friendly

orientation to services, CAMHD has renamed its SEBD services to "Supporting Emotional and Behavioral Development." Services to youth through the SEBD process occurs by virtue of the Memorandum of Agreement (MOA) with the Med-QUEST Division, which allows any QUEST or Medicaid fee-for services eligible youth who meet criteria for this designation to receive services through CAMHD. The process for referring youth for SEBD services has been widely disseminated to encourage easier access to needed behavioral health services. Information on the SEBD referral process can be found at the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/service-access/index.html. QUEST-eligible youth who received services in the quarter were 37.3% of the population. The total number of QUEST enrolled youth was down slightly from last quarter, when 680 youth with QUEST insurance were registered with CAMHD. Some QUEST-eligible youth may not have been screened through the SEBD process, and are eligible because of their educational or court-ordered status.

Table 4. Agency Involvement

Agency Involvement	N	%
DHS	195	11.1%
Court	482	27.4%
Incarcerated/Detained	142	8.1%
SEBD	458	26.0%
Quest	656	37.3%

Table 5. Diagnostic Distribution of Registered Youth

Any Diagnosis of	N	%
Disruptive Behavior	766	43.5%
Attentional	722	41.0%
Mood	607	34.5%
Miscellaneous	394	22.4%
Anxiety	302	17.1%
Substance-Related	260	14.8%
Adjustment	191	10.8%
Mental Retardation	31	1.8%
Pervasive Developmental	24	1.4%
Multiple Diagnoses	1,200	68.1%
Ave. Number of Diagnoses	2.0	

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 5). Thus, the reported percentages may exceed 100% because youth might receive diagnoses in multiple categories. The top three diagnoses of youth with authorized services in the quarter were disruptive behavior disorders (43.5%), attentional disorders (41.0%), and mood disorders (34.5%). This diagnostic breakdown has been fairly consistent over time. Those youth with miscellaneous diagnoses accounted for 22.4% of the CAMHD population. This category includes individual diagnoses that occur less frequently in the population including cognitive, psychotic, somatic, dissociative, personality, sexual, tic, impulse control, learning and eating disorders.

The majority of youth in the CAMHD registered population have co-occurring, or more than one diagnosis. In the reporting quarter 68.1% of registered youth had more than one diagnosis, with an average of 2.0 diagnoses per youth. This is a slight increase over the previous quarter (April-June 2004) when 67.3% had co-occurring disorders. For those with services authorized, the percentage of youth with multiple diagnoses was even higher (76.1%) with an average of 2.2 diagnoses per youth, which means that over three quarters of youth that received services within the CAMHD array in the quarter had co-

occurring diagnoses. The co-occurring diagnoses category includes any DMS identified disorder, whether behavioral, developmental, emotional or substance-related.

In the quarter, youth with substance-related diagnoses represented 17.5% of the population, an increase of 2.7% over the previous quarter. This statistic may not represent all youth with a substance-related impairment, or the number of youth with substance use identified as a target of intervention. Because diagnostic criteria for substance-related disorders require youth to exhibit a variety of symptoms and impairment, not all youth who use substances or who might benefit from interventions targeting substance use would be diagnosed with a substance-related disorder. Therefore, this statistic, which is drawn from the diagnostic category, is expected to underestimate the total number of youth experiencing a substance-related impairment. However, all youth registered with CAMHD that present in a treatment program with a substance related issue, receive treatment services as indicated.

Services

Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. At the case level, service data are constantly reviewed to provide services based on child and family needs, and provision within the least restrictive environment. Tracking of utilization of the services at the aggregate level allows for accurate accounting, and data-driven planning and decision-making.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a separate detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated, it is not possible to present actual utilization for the current reporting quarter (July 2004-September 2004). Therefore, service authorization data are presented here, which closely approximates the actual utilization for the quarter for most levels of care.

During the quarter, the largest percentages of youth served were authorized to receive services provided in the home and/or community, which consist of Intensive In-home services (46.3%) and Multisystemic Therapy (MST) (14.7%). The percentages of youth receiving services in both these in-home categories increased slightly over the last quarter's percentages. In the last quarter, (April-June 2004), 45.9 % of youth received Intensive In-home services and 12.2% of youth received MST.

Table 6. Service Authorization Summary (July 1, 2004-September 30, 2004).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-State	6	6	0.3%	0.6%
Hospital Residential	22	38	2.2%	3.9%
Community High Risk	10	11	0.6%	1.1%
Community Residential	130	166	9.4%	17.1%
Therapeutic Group Home	77	103	5.8%	10.6%
Therapeutic Family Home	112	137	7.8%	14.2%
Respite Home	0	0	0.0%	0.0%
Intensive Day Stabilization	0	0	0.0%	0.0%
Partial Hospitalization	0	0	0.0%	0.0%
Day Treatment	0	0	0.0%	0.0%
Multisystemic Therapy	105	142	8.1%	14.7%
Intensive In-Home	372	448	25.4%	46.3%
Flex	107	172	9.8%	17.8%
Respite	24	29	1.6%	3.0%
Less Intensive	49	112	6.4%	11.6%
Crisis Stabilization	6	15	0.9%	1.5%

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

The largest group of youth in an out-of-home setting received services in a Community-based Residential program (17.1%). The percentage of youth receiving these services was slightly down from the previous quarter's (April-June 2004) authorizations for 18.2% of the registered population. Youth receiving treatment while in Therapeutic Family Homes accounted for 14.2% of those served (up from 13.9% in the previous quarter), and Therapeutic Group Homes 10.6% (up from 9.9% in the previous quarter).

In the reporting period, Flex services were provided for 17.8% of youth served. Flex services are a broad category that range from mental health services not provided through a regular purchase of service contract, to travel for youth in off-island residential programs, to interpretive services. They may also include purchase of assessments. Respite Home services continued to have relatively low utilization with no youth accessing this service, as opposed to 3.4% of the served population receiving an authorization for this service last quarter.

Flex services have historically been a key component of the Hawaii system of care, and has allowed for flexible, and often low cost, supports to youth and families. Flexible services are designed primarily to maintain youth in their homes (prevent out-of-home placements) through supports that are not found in the regular array of services. Research has shown that flexible funds are associated with increased capacity of caregivers to provide care and "do their job."

Cost

CAMHD uses several sources to produce information regarding expenditures and the cost of services. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the fourth quarter of fiscal year 2004 (April-June 2004). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 7. Total cost increases include rate increases that were implemented for most providers in the quarter. Out-of home residential treatment services in Hawaii, including hospital-based residential treatment, accounted for 84.6% of service expenditures. This compares to out-of home residential treatment services accounting for 83.8% of the total costs in the third quarter of FY 2004, or a .8% increase in percentage of total expenditures. Youth in out-of-state treatment settings accounted for only 1.4% of total expenditures, which is .1% under last quarter's proportion of cost.

Table 7. Cost of Services (April 2004-June 2004)

Any Receipt of Services	Total Cost ($)	Cost per Youth ($)[a]	Cost per LOC ($)[b]	Cost per LOC per Youth ($)[b]	% of LOC Total ($)[b]
Out-of-State	174,491	24,927	161,684	23,098	1.4%
Hospital Residential	1,079,839	33,745	910,672	28,459	8.1%
Community High Risk	440,722	40,066	434,115	39,465	3.9%
Community Residential	5,004,678	28,275	4,476,321	25,290	39.8%
Therapeutic Group Home	2,238,189	23,560	2,016,809	21,230	17.9%
Therapeutic Family Home	2,082,794	15,428	1,674,935	12,407	14.9%
Respite Home	19,841	4,960	1,691	423	0.0%
Intensive Day Stabilization	0	0	0	0	0.0%
Partial Hospitalization	0	0	0	0	0.0%
Day Treatment	0	0	0	0	0.0%
Multisystemic Therapy	621,714	4,934	372,581	2,957	3.3%
Intensive In-Home	1,904,256	4,611	918,260	2,223	8.2%
Flex	4,200,095	22,341	173,718	924	1.5%
Respite	112,932	2,626	33,387	776	0.3%
Less Intensive	417,811	27,854	21,896	1,460	0.2%
Crisis Stabilization	82,842	6,903	45,138	3,761	0.4%

Note: [a] Cost per youth represents the total cost for all services during the period allocated to level of care based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care. [b] Cost per LOC represents unduplicated cost for services at the specified level

Hospital-Based Residential Services cost increased by 1% in the reporting quarter. The cost of Community-Based Residential Services remained the same as the previous reporting quarter. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter had the highest total cost per youth ($39,465 per youth), which has been consistent over time. For other types of residential treatment, the lowest cost per youth was for those who received services in Therapeutic Foster Homes ($12,407 per youth).

In-Home (Intensive In-Home and MST) and less intensive services accounted for 11.7% of the unduplicated cost of services, which is slightly lower than the last reporting quarter (January 2004-March 2004) percentage of total costs for those categories. Youth receiving Intensive In-Home services at some point during the quarter cost an average of $4,611 per youth ($2,223 of which was for Intensive In-Home service expenditures only), which continues to be significantly less than the cost per any youth in a residential program.

Youth who received Flex services during the quarter had a cost of $22,341 per youth. These youth most commonly receive other treatment services in addition to those flexibly funded. The total cost for the Flex service alone was $924 per month. The average cost per youth for a child receiving Flex at some point during the quarter also includes their service costs in other levels of care, and may include residential services. The high average total cost per youth for flex services suggest that youth in out-of home placements account for a high percentage of youth receiving flex services.

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Service's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for central office and Family Guidance Centers that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed analysis is conducted by CAMHD Administrative Services.

Services for Youth With Developmental Disabilities

Although the Memorandum of Agreement (MOA) between CAMHD and DDD ended in June 2004, the provision of services, supports and coordination for youth with mental retardation and developmental disabilities continued for the target population.

Respite Services

For July, August, and September, DDD met respite needs of the target population through the DDD service system. DOH case managers continued with assisting families to access other service options such as DDD Respite (via open enrollment), Home and Community-Based Service—DD/MR (HCBS-DD/MR) waiver program, and other DDD funded supports. The table below shows update utilization of various DDD services that families accessed to meet their needs.

Table 8. Other Service Options Utilized by CAMHD Respite Recipients

DDD Service	# of Users
*HCBS - DD/MR Waiver	48
**POS - Partnerships in Community Living (PICL)	14
***DDD Respite	36
Family Support Services Program (FSSP)	9

* Waiver admission as of 9/30/04
** PICL referrals for period of 7/1/04 – 9/30/04
* **DDD Respite (CAMHD recipients who applied in open enrollment of June 2004)
****Enrolled 7/1/04-9/30/04

Table 9. Expenditures to Date for CAMHD Respite by Island

Island	# Youth Served	% of Total Youth	Total Cost Per Island	% of Total Dollars Expended	Average Cost Per Youth
Oahu	73	55%	$148,303.93	44%	$2,031.56
Hawaii	34	26%	$89,714.00	27%	$2,638.65
Kauai	11	8%	$61,644.50	18%	$5,604.05
Maui	14	11%	$37,358.00	11%	$2,668.43
Total Youth	132	Total Dollars Expended (July 2002-September 2004)			$337,020.43

While families accessed DDD service options, there were no respite expenditures for the period July, August, September. The total dollars expended for the target population since July 2002 is $337,020.43.

Residential Services

The Individual Community Residential Support (ICRS) contract was extended until June 30, 2005. There are currently four individuals, two adults and two youth, being served under the ICRS contract. The extension was necessary to transition three individuals from a special treatment facility setting to other licensed residential placements. In addition, one youth continued to receive psychiatric treatment and hospital-based residential services. To date, all but one out of the four individuals under the current contract have been admitted to the HCBS DD/MR waiver program. The youth who is not in waiver continues to receive psychiatric treatment and hospital-based residential services.

Two of the three individuals residing in the special treatment facility setting are now adults and one adult is in the process of transitioning to an identified foster home. Efforts are being made to locate another potential foster home for the other adult. Residential supports for the remaining individual youth residing in the special treatment facility setting are currently being sought.

In addition, residential supports for the youth in the psychiatric facility must be addressed in order to transition this individual into the community.

Performance Measures

CAMHD uses performance measures to demonstrate sustainability and adequacy of services, results, infrastructure, and key practice initiatives. They measure the ability to maintain gains made since the inception of the Felix Consent Decree, and achieve CAMHD practice standards. CAMHD has set performance goals for each measure. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

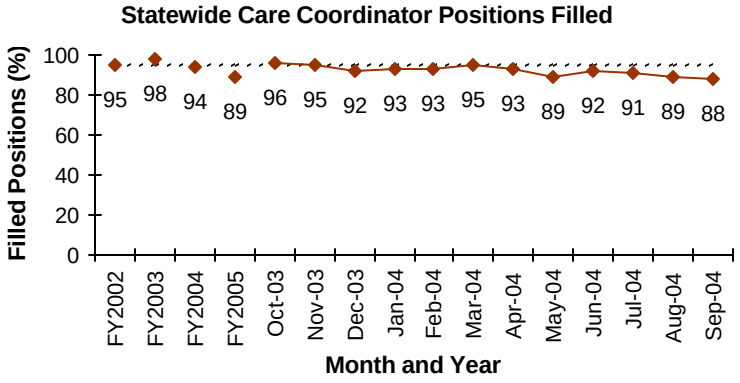
Those performance measures linked to previous Court Benchmarks are noted by an asterisk (*).

CAMHD will maintain sufficient personnel to serve the eligible population

Goal:

⇨ *95% of mental health care coordinator positions are filled**

Over the reporting period, CAMHD had an average of 89% of care coordinator positions statewide filled, which did not meet the performance goal, and was below last quarter's average of 91%. This quarter's data reflects the fourth consecutive quarter the performance goal was not met since this indicator began to be reported at the start of FY 2002. The length of time to fill care coordinator positions has increased over time, which is a variable impacts performance on this indicator.



The percentage of filled Care Coordinator positions over the quarter for each Family Guidance Center is displayed below.

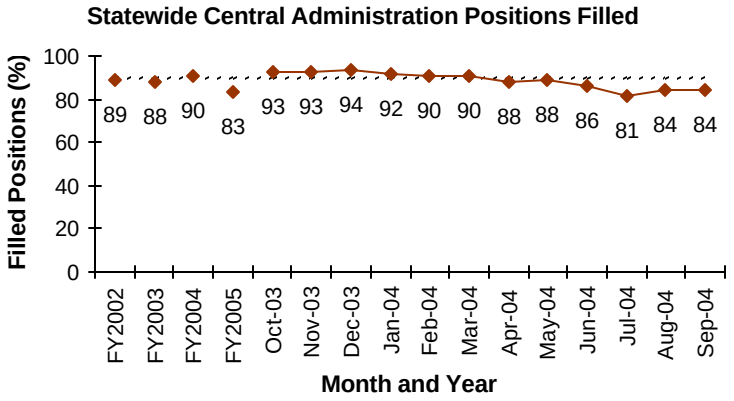
COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KAUAI
88%	87%	87%	75%	100%	90%	97%

As can be seen, vacancies in Central Oahu, Windward Oahu, Leeward Oahu, Maui, and the Big Island impacted the Statewide average. Each of these FGCs experienced an average of between one and two vacancies over the quarter. Active recruitment is underway for all sites.

Goal:

⇨ *90% of central administration positions are filled**

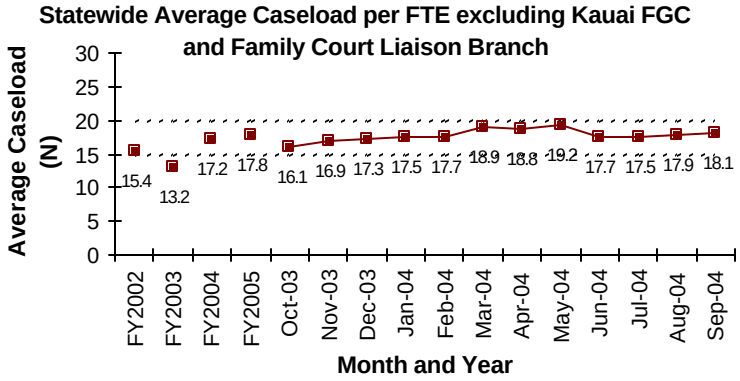
The performance target was not met, as an average of 83% of central administration positions were filled over the quarter, which is below the goal for the second consecutive quarter, and a decline from last quarter's filled positions (87%). Central Administration positions provide support for the infrastructure and quality management functions necessary to manage the statewide service system. Vacancies across the central administration's offices impacted this measure.



Goal:

⇨ *Average mental health care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.*

The average caseload for the fourth quarter was within the target range at 17.8 youth per full time care coordinator equivalent (FTE), which meets the performance goal for the measure. Each of the three months in the quarter met the performance expectation. CAMHD expects that care coordinator caseloads consistently fall in the range of 15 to 20 youth per full time care coordinator in order to provide quality intensive case management services. Average caseloads have been in the targeted range consistently sine the beginning of fiscal year 2004.



Average Caseloads by Family Guidance Center

	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
1st Quarter Average	18	20	18	18	15	19

The average caseloads performance target was met for all of the FGCs. The calculation of average excludes Kauai, which serves both high-end and low-end youth through the Mokihana project, and therefore have higher caseloads. Family Court Liaison Branch is also excluded because staff provide direct services to youth while at Detention Home or Hawaii Youth Correctional Facility, the majority of which are receiving care coordination from another Family Guidance Center. Other than the Honolulu FGC, all Family Guidance Centers are approaching the upper limit of twenty cases per care coordinator.

CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight

Goal:

⇨ Sustain within quarterly budget allocation.

CAMHD met the goal for sustaining within its budget. The reporting quarter for this performance measure is April-June 2004, which allowed for closing of the contracted agency billing cycle. The total variance from the budget for the reporting quarter was under projection by $549,000. These projections include service dollars that have been or will be encumbered and/or expended in the remainder of the fiscal year. Sufficient funds were encumbered for all expected service costs.

Expenditures in all categories were below budget. Service expenditures accounted for 18% of the variance. Central office expenditures accounted for 71% of the variance, and were largely impacted by the number of unfilled positions.

The total variance from the budget for FY 2004 was under projection by $2,142,000. The largest variance was in the service category.

Variance from Budget (in $1,000's)

	FY 2002 Average	FY 2003 Average	FY 2004 Average	2003.1	2003.2	2003.3	2003.4	2004.1	2004.2	2004.3	2004.4
Branch Total	$164	-$150	$20	$66	-$195	-$312	-$162	$134	$62	-$54	-$60
Services Total	$798	-$4,175	-$1,849	$315	$2	-$16,251	-$5,941	$59	-$3,963	-$3,389	-$101
Central Office Total	-$189	-$388	-$314	-$833	-$216	-$352	-$151	-$226	-$298	-$344	-$388
Grand Total	$773	-$4,713	-$2,142	-$452	-$408	-$16,915	-$6,254	-$33	-$4,200	-$3,787	-$549

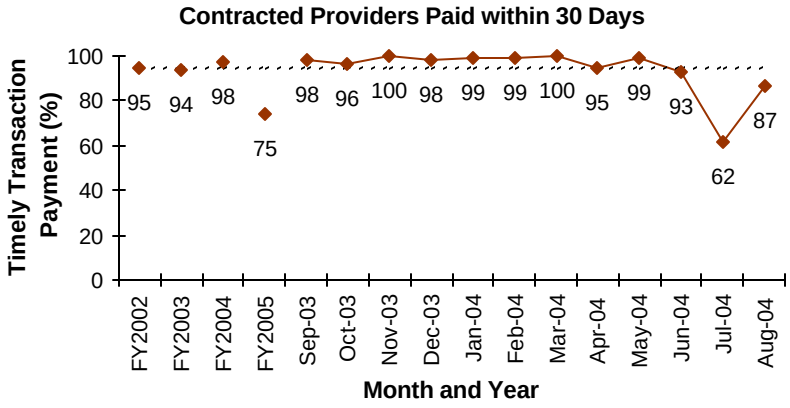
CAMHD will maintain timely payment to provider agencies

Goal:

⇨ *95% of contracted providers are paid within 30 days*

The target goal was not met for the quarter as an average of 81% of contracted providers paid within the 30-day target. This was a decline over last quarter's result of 97% paid within 30 days. The primary impact on timely payment to providers occurred as the result of a determination by the Department of Accounting and General Services (DAGS) that it could no longer accept electronic billings for service provision because of State regulations. The situation was remedied through an exemption based on CAMHD's need to comply with the Health Insurance Portability and Accountability Act (HIPAA), and fully supported by the State's Uniform Electronic Transitions Act that allows for electronic transactions in governmental business.

As standard for reporting, the first quarter's data is available for the months of July and August, as September's payments are in mid-cycle as of this report. June 2004 data is reported in the quarter's average. As seen below, July saw the brunt of the impact of the DAGS ruling, and August continued to experience a residual effect. It is anticipated that performance will rebound on this measure based on the State Comptroller's approval, which now allows CAMHD to provide electronic invoices.

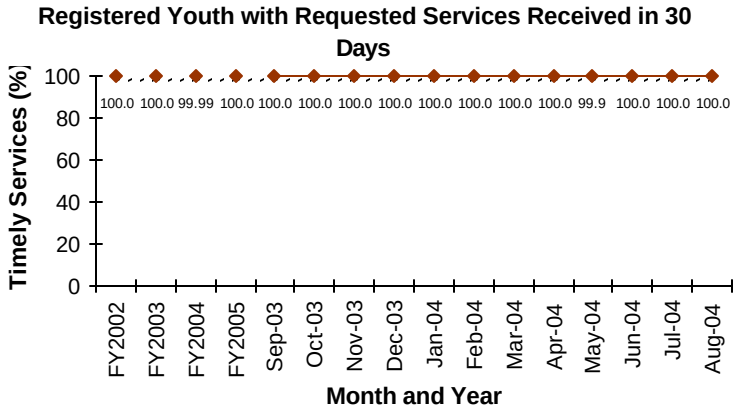


CAMHD will provide timely access to a full array of community-based services

Goal:

⇨ 98% of youth receive services within thirty days of request*

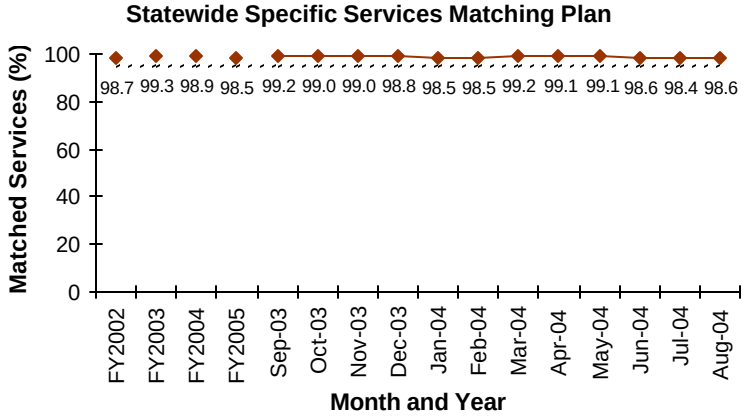
The goal was met for the quarter with 99.9% of youth provided timely access to services. This is the first time a service gap has been seen since August of 2001. Data are for the first and second month of the reporting quarter (July and August 2004) as third month data are not available at the time of publication. June 2004 data are included in the average for the quarter.



Goal:

⇨ 95% of youth receive the specific services identified by the educational team plan*

CAMHD continued to demonstrate strong performance on this measure. Over the quarter 98.5% of youth received the specific services identified by their team plan. These youth received services within 30 days, but they were not the exact service selected by their service teams. Data are for the first and second month of the reporting quarter (July and August 2004) as third month data are not available at the time of publication. June 2004 data are included in the average for the quarter. This measure also includes SEBD youth who do not have an educational plan.



In the first quarter, service mismatches occurred in twenty complexes versus sixteen in the previous quarter. Hilo continued to have mismatches for three youth versus six youth in each of the previous two quarters. Pearl City

Complex was the outlier among the complexes, with four mismatches. The Pearl City mismatches affected two youth over a two-month period. One mismatch occurred due to complications in finding a well-matched therapeutic foster home.

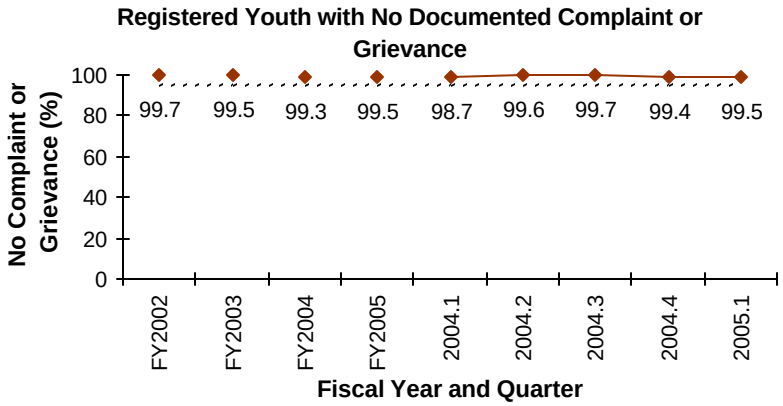
The remaining complexes experiencing mismatches had two or less.

CAMHD will timely and effectively respond to stakeholders' concerns

Goal:

⇨ 95% of youth served have no documented complaint received*

99.5% of youth served in the quarter had no documented complaint received, which exceeds the performance goal. The target was met across all Family Guidance Centers.

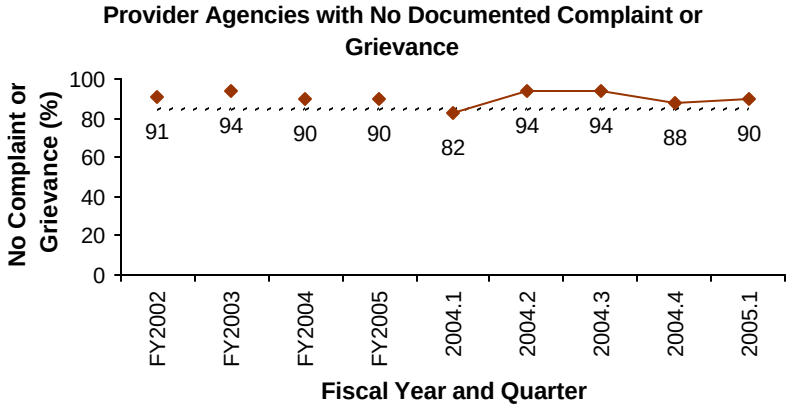


In the quarter, there were 9 youth with documented complaints representing 8 complexes statewide. One of the complaints was not specific to a youth or a complex as it was against a program site relating to general care of youth. This compares to 12 youth with documented complaints from 12 complexes in the last quarter (April-June 2004), and 5 youth representing 4 complexes in the previous quarter (January-March 2004). There was one complaint each for youth who were part of the following complexes: King Kekaulike, Hana, Kea'au, Pahoa, Honokaa, Castle, Leilehua, and Kapolei. There were no noticeable trends in the data.

Goal:

⇨ 85% of provider agencies have no documented complaint received

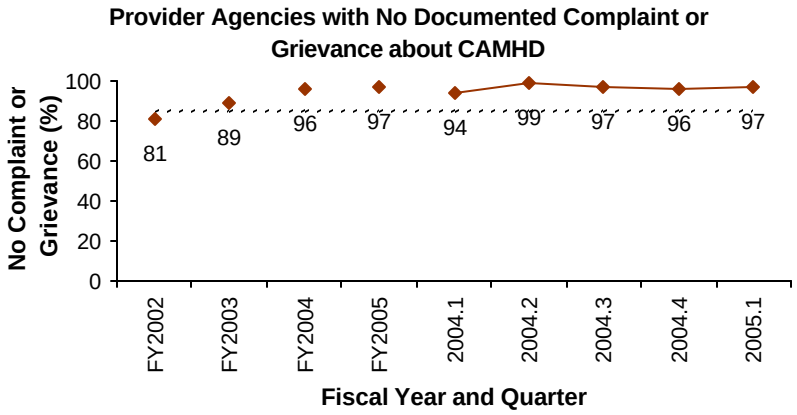
90% of provider agencies had no documented complaint about their services, which met the performance goal. This represents an improvement in performance since the last quarter. CAMHD has consistently met the targeted performance goal in this measure since it was established in June 2001.



Goal:

⇨ 85% of provider agencies will have no documented complaint about CAMHD performance*

In the quarter, 97% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD, which met the goal for this measure. This measure has consistently met the performance goal since the beginning of FY2003.

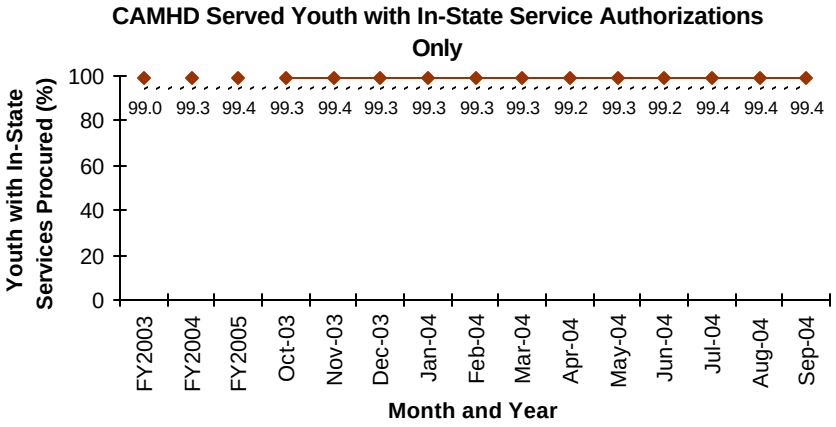


Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting

Goal:

⇨ 95% of youth receive treatment within the State of Hawaii*

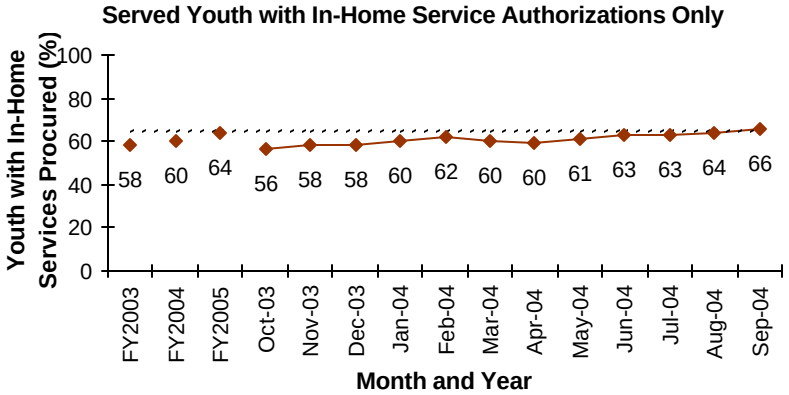
In the quarter, an average of 99.4% of CAMHD registered youth served received treatment within the State, which exceeds the goal. Six youth received services in out-of state treatment settings in the quarter, one more than last quarter. These data represent youth registered with CAMHD who were in out-of-state treatment settings in the reporting quarter.



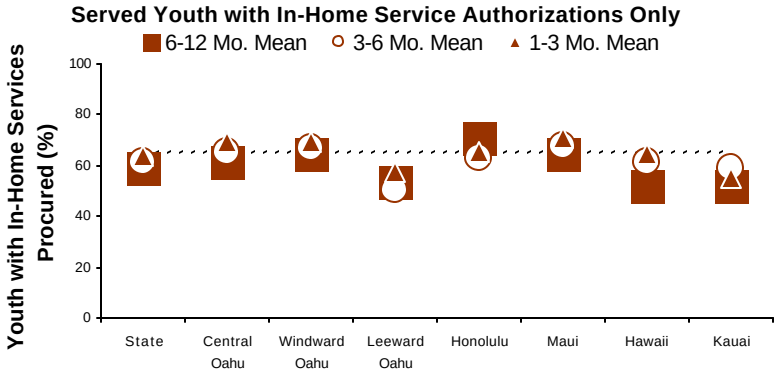
Goal:

⇨ 65% of youth are able to receive treatment while living in their home

The quarter's data showed that an average of 64.3% of youth were served in their home communities throughout the quarter, which is only .7% away from meeting the performance goal. The quarter ended with 66% of youth served while living at home, which meets the targeted goal for this important measure. There has been a steady increase in performance over the last three years in serving youth while they are living in their own homes. Increases in this measure over the recent months have been largely driven by increased new enrollment of youth in the SEBD program. The data reflect a 3% increase over last quarter's performance, and are the best results for CAMHD to date.



There was variable performance across the Family Guidance Centers in meeting the goal as can be seen below. The goal was met for Central Oahu FGC (69.1% served in their homes), Windward Oahu (69% served in-home), Honolulu FGC (65.5% served in-home) and Maui FGC (70.9% served in-home) and nearly met for Hawaii FGC (64.6% served in-home).

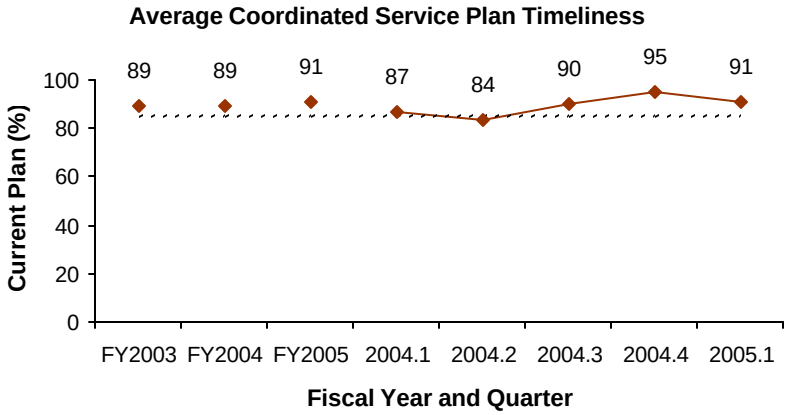


CAMHD will consistently implement an individualized, child and family centered planning process

Goal:

⇨ 85% of youth have a current Coordinated Service Plan (CSP)*

CAMHD's performance in this measure met the performance goal for the reporting quarter with 91% of youth across the state having a current CSP, which was 4% below last quarter's performance. All Family Guidance Centers with the exception of Windward Oahu met the performance goal in the reporting period.



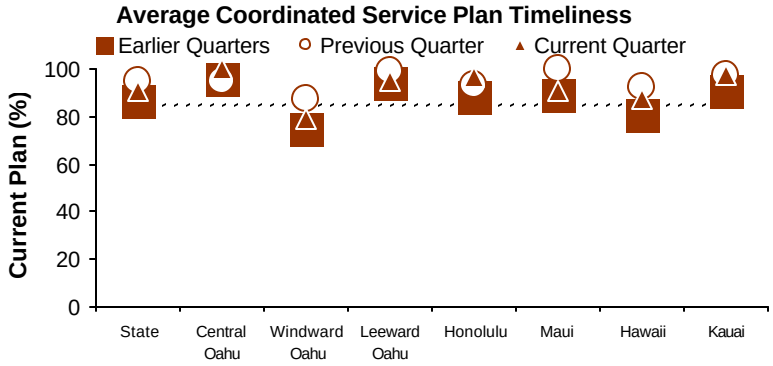
Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed, but does not include youth awaiting an assessment for determination of SEBD.

"Current" is defined as having been established or reviewed with the CSP team within the past six months. Quarterly reviews of timeliness are conducted to assess for current CSPs. Registered youth receive an initial Coordinated Service Plan within 30 days of determination of eligibility.

Average CSP Timeliness by Family Guidance Center

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KFGC
100	95	91	79	96	87	97

Trend data for each FGC are displayed below. Timeliness improvements were seen in Central and Honolulu FGCs.



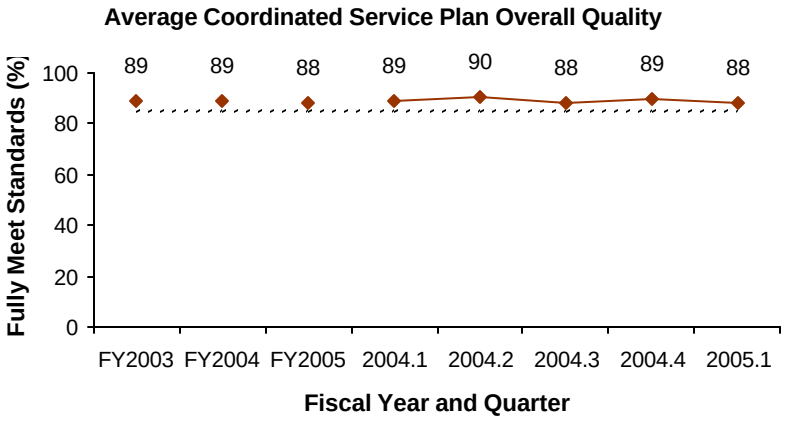
Central FGC, which achieved 100% of CSPs meeting the timeliness goal, attributes its success to a booster training on CSP development held in September, as well as enhanced supervision and accountability for assuring each youth has a current CSP.

Windward Oahu, which met the goal last quarter, achieved timely CSPs for only 79% of youth in the reporting quarter. Windward has had several vacancies, and has recently hired two new staff, which is anticipated to help address the timeliness of plans. Additional management efforts will be implemented over the next quarter to assure each child has a current CSP.

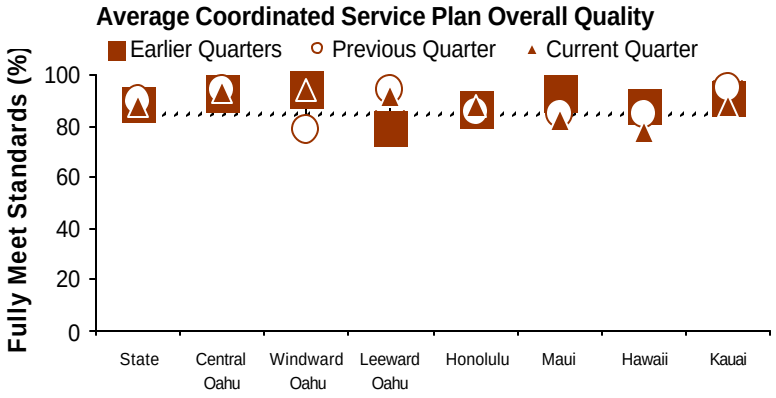
Goal:

⇨ 85% of Coordinated Service Plan review indicators meet quality standards*

The goal for this measure was met in the reporting quarter with 88% of CSPs sampled meeting overall standards for quality. Quarterly reviews of CSPs against standards for effective plans are a part of quality monitoring within each FGC. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, a clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and other key measures. CSP quality is supported by training and consultation through the CAMHD Practice Development Section. These data are systematically referred to in this section and also reviewed by the FGC quality assurance committees. The statewide data for quality of CSPs are displayed below.



As seen in the next chart, the goal was met or exceeded by all FGCs with the exception of Maui and Hawaii FGCs. Hawaii FGC had four new care coordinators begin employment during the quarter. Based on the review of their plans, a focused training on CSP development is scheduled.



Maui FGC experienced a decline in the quality of plans for the second consecutive quarter. The FGC arranged for an in-service training and increased the specificity of feedback to care coordinators as part of their quality improvement activities to improve CSPs.

Windward and Leeward FGCs showed improvement in the quality of their coordinated service plans.

Mental Health Services will be provided by an array of quality provider agencies

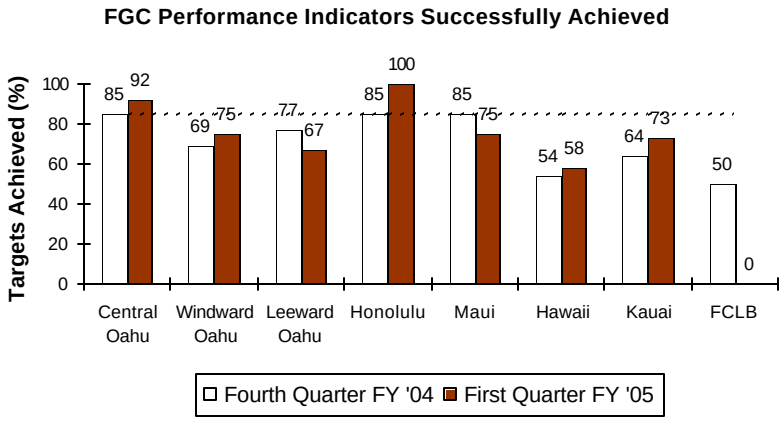
Goal:

⇨ 85% of performance indicators are met for each Family Guidance Center

Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: expenditures within budget, grievances, access to services (service gaps/mismatches, least restrictive environment (served in-home), timeliness and quality of coordinated service plans, performance on internal reviews, and improvements in child status.

The goal of meeting at least 85% of the performance indicators was met by Central Oahu and Honolulu FGCs. On average across all FGCs, 67.5% of all goals were met in the quarter, compared to 71% in the last quarter, and 64% in the previous quarter. The Family Guidance Centers generally did well in indicators of adequate caseloads, timely access, response to concerns, serving youth in the State, and youth showing improvements as measured by the CAFAS or ASEBA.

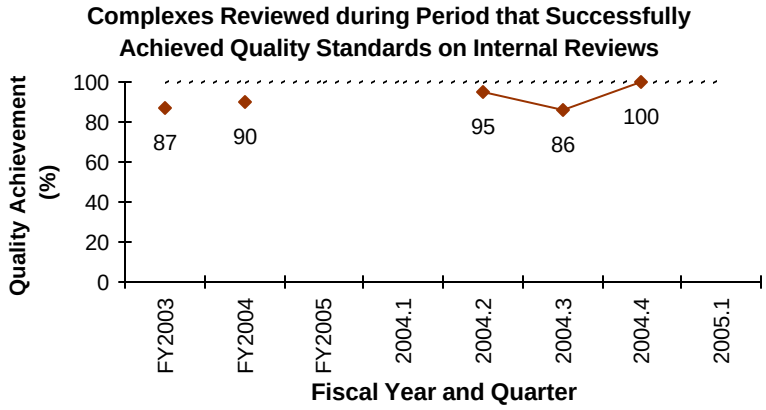
Any performance goals not met by a Family Guidance Center are addressed through specific improvement strategies developed by the FGC internal quality assurance committee, and reported up through the CAMHD Performance Improvement Steering Committee. The FGC management team tracks the implementation of each improvement strategy.



Goal:

⇨ 100% of complexes will maintain acceptable scoring on internal reviews*

No complexes were reviewed in the reporting quarter. Internal Reviews were resumed in October. Results to date are displayed below.

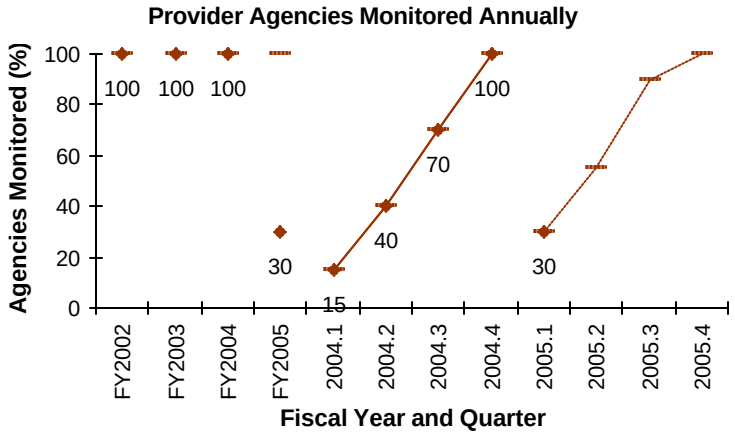


Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ 100% of provider agencies are monitored annually

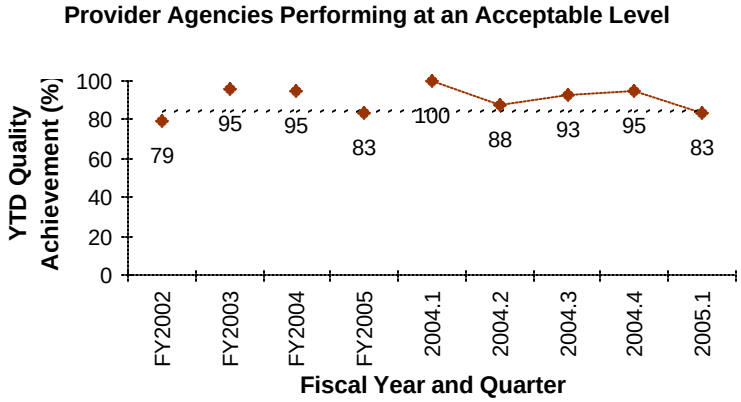
The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. In the quarter, 30% of all agencies contracted to provide direct mental health services were monitored as scheduled, which met the targeted goal. Six agencies, representing eight contracts and three levels of care were monitored in the first quarter.



Goal:

⇨ 85% of provider agencies are rated as performing at an acceptable level

In the reporting quarter, 83% of the provider agencies reviewed was determined to be performing at an acceptable level, which is slightly below the goal for this measure. Provider agencies are reviewed across multiple dimensions of quality and effective practices. Several of the residential programs struggled with their performance in the quarter, and are implementing focused corrective actions. Corrective actions are carefully monitored for implementation and impact on changes in practice.



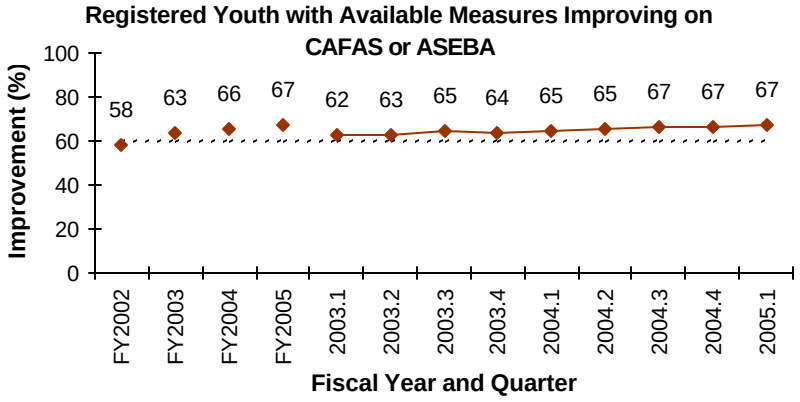
There were several provider agencies reviewed in the quarter that experienced programmatic deficiencies that compromised their ability to provide effective treatment services. The agencies, both community-based residential programs, were required to implement corrective actions, and extensive consultation was provided by CAMHD. One of the programs has made substantial gains through strengthening their clinical program, and the other is in the early stages of implementing programmatic improvements.

CAMHD will demonstrate improvements in child status

Goal:

⇨ 60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA)*

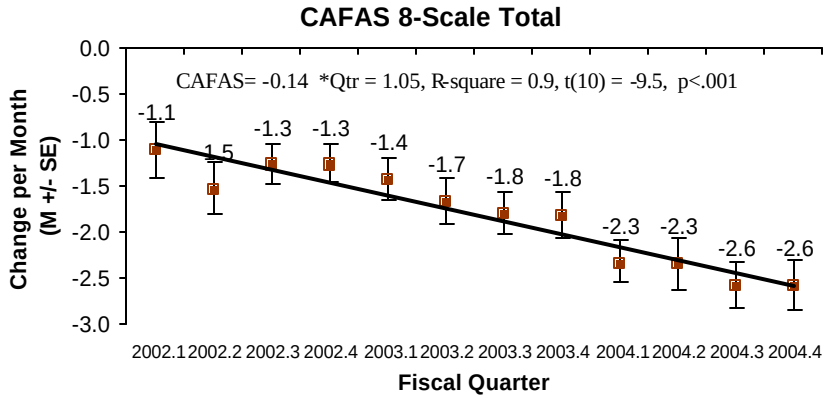
To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to complete the CAFAS and ASEBA for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%.



In the reporting quarter, for youth with data for these measures, 67% were showing improvements since entering the CAMHD system, which meets the performance goal. There has been a steady upward but stabilizing trend in functional improvements for youth served by CAMHD. Child functioning as measured by these scales has improved by 9% since the end of FY 2002.

CAMHD recently examined the rate of child improvements over time through a study entitled, "Child Status Measurement: System Performance Improvements During Fiscal Years 2002-2004." Analyses were conducted across measures of functioning, service needs, and symptomatology.

Displayed below is an analysis of average change per month in functioning over the course of youths' service episodes. In this figure, lower scores indicate greater improvement in child functioning. At the end of the study, youth were improving significantly more rapidly than at the beginning of the study. This finding of significant improvement was consistent across all adult (parent, teacher, clinician) reported measures of child status but not on the youth self report ASEBA, which demonstrated consistent not significant improvement rates throughout the study period.



Average Monthly Within Client Slopes (i.e., Change per Month) During Service Episode for the Period July 2001-June 2004

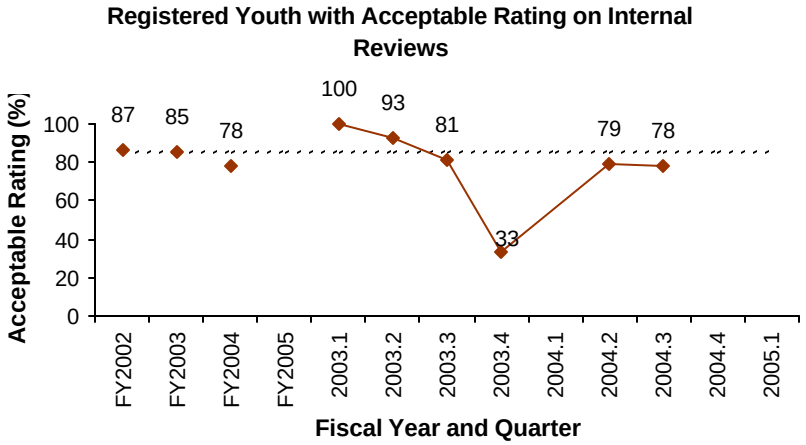
These improvements in child status coincided with the successful implementation of CAMHD initiatives including a) dissemination of evidence-based practices, b) development of care coordination practice, c) increased information feedback to stakeholders, d) improved utilization management, e) adoption of the use of performance measures statewide, f) the restructuring of quality improvement operations, and g) the integration of practice-focused performance management at the various levels of the service system. This data presents some of the most compelling information to date regarding the impact of the mental health service system improvements on the health outcomes for youth served.

The full study can be found at the CAMHD website at: http://www.hawaii.gov/health/mental-health/camhd/resources/rpteval/library/pdf/er-ge/ge010.pdf.

Goal:

⇨ 85% of those with case-based reviews show acceptable child status

No Internal Reviews were conducted in the quarter. The most recent results are displayed below.



Families will be engaged as partners in the planning process

Goal:

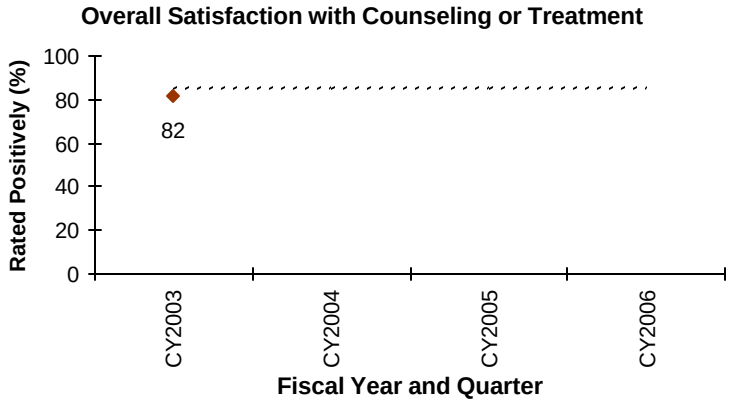
⇨ 85% of families surveyed report satisfaction with CAMHD services

The following information is repeated in its entirety from the previous Integrated Monitoring Report (April-June 2004). Discussed are the results of the ECHO™ satisfaction survey, which is administered annually. The next survey will be administered in Spring 2005. The next Integrated Monitoring Report will feature comparisons of Hawaii's ECHO™ administration with national data.

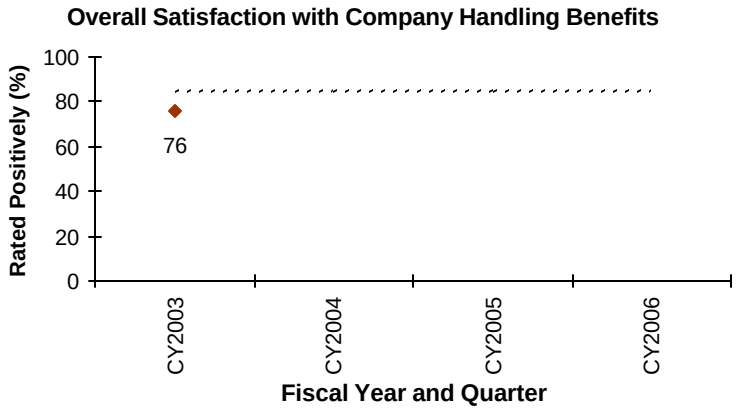
In Spring of 2004, CAMHD initiated its annual administration of the Experience of Care and Health Outcomes (ECHO™) survey. The survey was selected because it builds on widely used instruments for behavioral health care quality assessment, and was designed with the unique needs of populations similar to that served by CAMHD. It assesses consumer experiences with a number of aspects of care including quick access to care, communication with clinicians, information provided by clinicians, consumer involvement in treatment, information about treatment options, and the behavioral health organization's administrative services. The survey collects useful information about the characteristics of youth and their families. Satisfaction and consumer experiences with services are important for mental health delivery systems to understand in working toward optimal care and outcomes. The comprehensive report of this year's survey results (assessing satisfaction for calendar year 2003) can be found on the CAMHD website at:
http://www.hawaii.gov/health/mental-health/camhd/resources/rpteval/cs/library/pdf/er-cs/cs003.pdf.

Another advantage of using the ECHO™ survey is that it allows for comparison of CAMHD results with other children's mental health delivery systems. Each fall, data from all the behavioral health plans across the country that use the ECHO™ are released, and CAMHD will be able to use this information to further refine its benchmarks on the indicators selected to measure quality.

Results regarding two aspects of overall satisfaction are presented below. The survey found that 82% of CAMHD caregivers were satisfied overall with their child's counseling or treatment. This provides baseline data for this measure, and is just below targeted performance. These data will help CAMHD identify any needed improvements on this indicator.



Another key measure of satisfaction falls under the title of "Overall Satisfaction with the Company Handling Benefits." This question allowed respondents to rate their overall satisfaction with CAMHD's management of their child's behavioral health care. Results for this indicator fell below targeted performance with 76% of those surveyed satisfied with CAMHD's handling of their child's care. The detailed analysis provided in the survey will help CAMHD identify specific improvements in managing care for consumers.



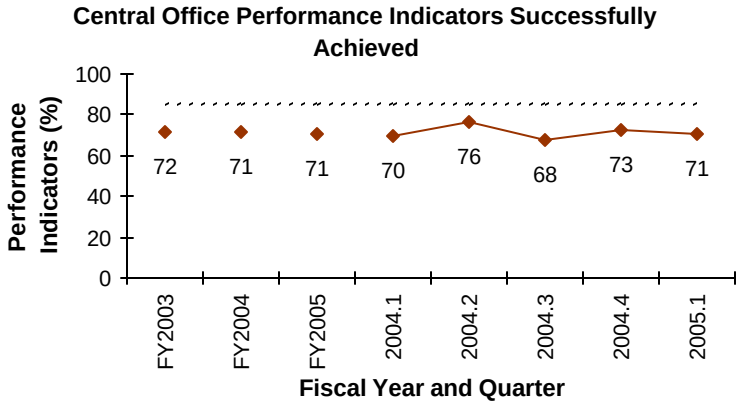
There will be state-level quality performance that ensures effective infrastructure to support the system

Goal:

⇨ 85% of CAMHD Central Office performance measures will be met.

CAMHD's Central Administrative Offices utilize performance measures for each section as accountability and planning tools. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team (EEMT). There are a total of 38 measures currently tracked by EEMT.

In the fourth quarter, 71% of measures were successfully met, which falls short of meeting the performance goal for this quality indicator, and slightly last quarter's performance. The measures that fell below expectations continued to be impacted by staff vacancies.



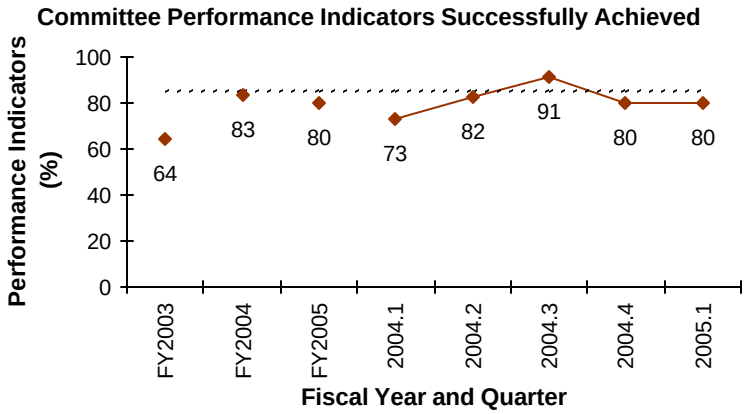
Improvements for Central Office performance measures are managed by respective sections of CAMHD. When solutions require a broader organizational intervention, these are discussed on the regular Expanded Executive Management Team level, and are tracked for implementation.

Goal:

⇨ 85% of CAMHD State Committees performance measures will be met.

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Credentialing, Safety and Risk Management, Grievance and Appeals, Utilization Management, Evidence-based Services, Compliance, Information Systems Design, and Training. A total of 22 measures are tracked and reported on in the monthly meeting. Similar to Central Office measures, results for each indicator are discussed in the monthly PISC meetings in order to identify improvement strategies that are implemented by respective CAMHD section managers.

In the quarter 80% of performance measures were met through the work of the CAMHD Committees, which does not meet the goal for this quality indicator. Focused improvement initiatives have had a major impact on improved performance.



Summary

The majority of performance goals were met or exceeded in the fourth quarter. The asterisked measures are those linked to historical Federal Court benchmarks. Of these "sustainability measures", all indicators met the performance goal in the reporting quarter except for filled Care Coordinator positions, which was 6% below targeted performance, and Central Administration positions filled, which was 7% below target. Both of these measures represent vacancies. Several of the non-core measures were also below benchmark. The areas of strength were caseload sizes, funding, timely access to services, system responsiveness to stakeholder concerns, serving youth within the State, timely and quality service plans, and quality service provision.

The following were measures that met or exceeded goals:

- Care Coordinator caseloads within the range of 1:15-20 youth
- Maintaining services and infrastructure within the quarterly budget allocation
- Youth receiving services within 30 days of request*
- Youth receiving the specific services identified on their plan*
- Timely and effective response to stakeholder concerns:*
  - Youth with no documented complaint received
  - Provider agencies with no documented complaint received
  - Provider agencies with no documented complaint about CAMHD performance
- Youth receiving treatment within the State of Hawaii*
- Coordinated Service Plan timeliness*
- Coordinated Service Plan quality*
- Monitoring of provider agencies
- Improvements in child status as demonstrated by CAFAS or ASEBA*

The following measures demonstrated a stable or improving trend, but did not achieve the targeted goal:

-
- Youth receiving treatment while living in their homes
- Central Office performance indicators

The following measures were below targeted performance with observed decreases, and will require implementation of improvement strategies as discussed in the body of this report:

- Filled Care Coordinator positions*
- Filled Central Administration positions*
- Contracted providers paid within 30 days
- State Committees' performance indicators
- Family Guidance Center performance indicators
- Quality service provision by provider agencies

There were no Internal Reviews conducted in the quarter, and thus no available data for the following measures:

- Child Status as measured by Internal Review Results
- Complexes reviewed during the period that maintained acceptable scoring on Internal Review*

Satisfaction with CAMHD Services has converted to an annual measure, and there are no new data for the following measures:

- Overall satisfaction with counseling or treatment
- Overall satisfaction with company handling benefits

The reporting period extended the trend experienced by CAMHD over the past several years in demonstrating stable services and service-delivery infrastructure in most areas. Issues of particular concern to CAMHD over the last several quarters are in the areas of vacancies and the impact of vacancies in key areas in both the Family Guidance Centers and the Central Administrative offices. Over time, the ability to fill positions, as well as the extended length of time it takes to fill positions, has impacted performance in the vacancy measures, as well as the performance of CAMHD sections. The performance measures in these areas where results are below target directly correlate to the staffing challenges of those offices.

Specific challenges impacting measures are the ability to fill the Clinical Services Office Transition Specialist, several positions in the Management Information Systems section, and in the Performance Management Office. Active recruitment is underway at all levels for positions that are approved to fill. CAMHD is also attempting to use a flexible approach to address the need to provide advanced clinical monitoring and technical assistance on organizational development to provider agencies that are struggling to serve youth with the most challenging behaviors A request for proposals for this level of clinical monitoring is under consideration by the Department. The goal of this RFP is to improve provider agencies' ability to provide effective treatment services, as well as to improve the timeliness and quality of feedback to the agencies.

The State Committees' measures that did not meet performance targets are under active management by the Performance Improvement Steering Committee (PISC) and the Expanded Executive Management Team. Family Guidance Center quality measures that need improvement are addressed through the FGC quality assurance committees, CAMHD supervision structure, and are part of the PISC agenda. CAMHD is refining the analysis afforded through quarterly and annual monitoring of the FGCs to improve performance in areas that are not meeting objectives.

Another area of concern is the loss of the ability to flexibly access informal support services and other related ancillary services on an individual basis may lead to confusion within the teams and disruption of support services. CAMHD is currently pursuing multiple means of sustaining the ability to flexibly access informal services for the populations. It is expected that these changes may require release of a Request for Proposal (RFP) for an agency to manage "flex services" or a change in statute that allows CAMHD to provide flex services.